Health Canada Santé Canada

Interchange '95:

A Canadian Forum to Collaborate on Cervical Cancer Screening Program Implementation Strategies

February 27, 28 and March 1, 1995

Ottawa, Ontario, Canada

Canada

Our mission is to help the people of Canada
maintain and improve their health.

Health Canada

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* *Following Branch restructuring in the summer of 1995, the new names are Disease Prevention, Systems for Health Directorate and Family and Child Unit, Population Health Directorate.*

Executive Summary

In February 1995, Health Canada sponsored ***Interchange '95 -A Canadian Forum to Collaborate on Cervical Cancer Screening Program Implementation Strategies***. The primary objectives of ***Interchange '95*** were to,

- To identify the factors that affect the implementation of comprehensive provincially-based cervical cancer screening programs.
- To focus on three specific components of a comprehensive cervical cancer screening program, namely information systems, quality improvement and recruitment.
- To develop an approach through which information with respect to program development, organization and data can be shared at provincial and national levels.

The need to establish a comprehensive cervical cancer screening program is based on the knowledge that screening asymptomatic females can identify pre-invasive cancer of the cervix, and appropriate treatment can reduce morbidity and mortality among populations. **There is no other cancer for which screening reduces the incidence of invasive disease as dramatically and predictably as cervical cancer**.

Since the reduction of the incidence of invasive cervical cancer can be achieved by implementing organized cervical cancer screening programs that are well managed and cover a large proportion of the female population, it is hoped that ***Interchange '95 - A Canadian Forum to Collaborate on Cervical Cancer Screening Program Implementation Strategies*** will stimulate stakeholder activity, raise public awareness of cervical cancer and provide national impetus to build provincially based, comprehensive cervical cancer screening programs.

The format of the workshop was designed to facilitate the development or enhancement of intra-provincial and interprovincial working relationships and consisted of plenary sessions and working groups. Provincial representatives worked together in small groups to develop an understanding of the barriers to implementation or enhancement of their provincial programs and to suggest methods of overcoming these barriers. The first day of the workshop focussed on the components of a comprehensive screening program and the rationale to support the development and evaluation of such programs, with descriptions of a comprehensive program in Victoria, Australia and of the status of the most advanced programs in Canada, namely those in British Columbia and Nova Scotia. The second day addressed the issues of recruitment, information systems and quality improvement in plenary sessions and in working groups. The final morning consisted of working group sessions on developing action plans for the provincial programs and defining the role of the provincial and federal governments and that of the relevant professional and non-governmental organizations.

The workshop was sub-divided into five regional working groups: British Columbia/Alberta, Saskatchewan/Northwest Territories, Manitoba/Ontario, Quebec/New Brunswick/Prince Edward Island and Nova Scotia/Newfoundland. The working groups were asked to identify factors that influence or have the potential to influence the development, implementation and maintenance of a comprehensive cervical cancer screening program with specific attention to recruitment, quality improvement, and information systems. The workshop participants based their discussion on the recommendations of the 1989 National Workshop on Screening for Cancer of the Cervix, information from the plenary speakers, and supporting documentation provided by Health Canada (e.g., working papers on quality assurance in laboratories, health service research, health economics etc.).

The workshop highlighted the current status of cervical screening in the provinces and the barriers to implementation of a comprehensive program were identified. Action plans to achieve such programs were developed or affirmed using the recommendations of the 1989 Workshop. Recruitment of unscreened and underscreened women, the need for comprehensive information systems and quality improvement were addressed at this Workshop and further activities are being planned around these issues at national and provincial levels.

Introduction

In the six years since the National Workshop on Screening for Cancer of the Cervix, a variety of activities have been undertaken in Canada at the research and programmatic levels as well as at the provincial/territorial and national levels. Indeed, the recommendations from this 1989 workshop provided the direction necessary for the ultimate development of provincially based, comprehensive cervical screening programs. Subsequent workshops and meetings took subsets of these recommendations and focused on developing the preconditions to meet these recommendations. While these workshops were useful in keeping the issue on the table, they focused on the development of the scientific and technical expertise more than the policy climate.

In planning this 1995 national workshop, the Organizing Committee made the decision to focus the agenda at exploring the policy level. The workshop was designed not to revisit any one specific recommendation of the 1989 workshop but to determine where we have come since 1989 and why we have not come further. Specifically, the objectives of the workshop were:

- To identify the factors that affect implementation of comprehensive provincially based cervical screening programs.
- To focus on three specific components of a comprehensive cervical cancer screening program, namely information systems, quality improvement, and recruitment.
- To develop an approach through which information with respect to program development, organization, and data can be shared at the provincial and national levels.

From the previous workshops we knew that the main challenge lay not in forging an agreement on the need for a comprehensive cervical screening program but in going one step further and developing mechanisms to get from "here to there?" The workshop was designed to attract a combination of expert technical opinion on the scientific and medical considerations needed for a given piece of the cervical screening puzzle in addition to expert policy opinion on the contextual factors that affect planning and program development. Furthermore, it was designed such that each participant could leave the workshop with an understanding of the multiplicity of factors feeding into the development of a comprehensive cervical screening program and to be able to compare their individual understanding with that of their own colleagues as well as those from other provinces. As a result, invitations were issued to individuals who came from a variety of fields and who could represent, from a provincial perspective, a given area which would be involved in the formation of the political environment conducive to the development of an infrastructure to support a comprehensive cervical cancer screening. Representatives from Health Canada and the Canadian Cancer Society were also present.

It is our hope that these Proceedings will contribute to the understanding of how the three days helped to direct the next steps in pursuit of the development of comprehensive cervical screening programs.

Format of the Workshop

The format of the workshop was designed to facilitate the development or enhancement of intra-provincial and interprovincial working relationships and consisted of plenary sessions and working groups. Using the recommendations of the 1989 workshop and information from the plenary speakers as background, provincial representatives worked together in small groups to develop an understanding of the barriers to implementation or enhancement of their provincial programs and to suggest methods of overcoming these barriers. The first day of the workshop focussed on the components of a comprehensive screening program and the rationale to support the development and evaluation of such programs, with descriptions of a comprehensive program in Victoria, Australia and of the status of the most advanced programs in Canada, namely those in British Columbia and Nova Scotia. The second day addressed the issues of recruitment, information systems and quality improvement in plenary sessions and in working groups. The final morning consisted of working group sessions on developing action plans for the provincial programs and defining the role of the provincial and federal governments and that of the relevant professional and non-governmental organizations.

Plenary Sessions

The format of the plenary session included an initial overview of four established programs in British Columbia, Nova Scotia, Australia and South and Central America. This was followed by presentations of key structural components of program development. The three key themes of the workshop, recruitment, quality assurance and information systems were addressed in separate presentations.

First, Dr. George Anderson, Director, Section of Gynaecological Cytology, B.C. Cancer Agency, reviewed the statistical incidence and mortality data from British Columbia. From 1955 to 1993, the population over the age of 20 years has increased more than three-fold while the total number of new cases of women with cancer of the cervix and the incidence rate have decreased dramatically. In addition, mortality has steadily decreased. The incidence rate of carcinoma-in-situ of the cervix has increased in most age groups from 1972 through to 1980 and then decreased until 1990. The highest incidence rate is amongst those women age 20-34 years. The highest percentage of women screened as a proportion of the population at risk are in this age group (68% in 1990). It was noted that in 1988-1989, only 12% of women who were screened were recommended to undergo other investigations (4% repeat cytology and 8% colposcopy).

Dr. Robert Fraser, Executive Director, Nova Scotia Gynaecological Cancer Screening Programme (NSGCSP), made a presentation on behalf of the NSGCSP. This program dates back to the early 1960's with a central registry established in 1978. The Programme was officially recognized by the Nova Scotia Department of Health in 1991 having benefitted from the experience of British Columbia, New Zealand and Australia. Since 1992, a formal Board for the Programme has been in place with a defined mandate and mission. Several committees provide input from colposcopists, histopathologists, cytologists, and information system analysts. This structure coordinates the 9 cytology laboratories, histopathology laboratories doing gyne-histopathology, and the 20 colposcopy centres. An evaluation of the first three-years of the Programme will be available later this year.

The Medical Director of the Victorian Cervical Cytology Registry, Dr. Heather Mitchell, provided an overview of cervical cancer screening in Australia. Development of the program required identification of the key elements of a screening program and then a delineation of the Federal and State responsibilities. Specific strategies for recruitment were reviewed and included community activities, letters of invitation and special initiatives for women of non-English speaking backgrounds. The success of such a program requires effective quality assurance. Dr. Mitchell outlined the process for development of performance standards/indicators. These have been formalized and are being piloted in 1995. An emphasis was placed on ensuring that there are reasonable expectations of a screening program such that "deliverables" can be provided.

Dr. Eric Nicholls, Regional Advisor in Non-Communicable Diseases, Pan-American Health Organization, presented a description of screening activities on behalf of the Pan-American Health Organization. Each South American country has a different screening program in place. Incidence rates in Brazil reach a level of 83 per 100,000 women annually (compared to 7 in Connecticut, U.S.). The potential pitfalls of any screening program throughout the process were reviewed. Recruitment into a program was considered from the perspective of the user and the provider. A major issue for recruitment is the use of mass media to provide information to the target audience. This should precede other key issues such as quality assurance.

Dr. Elizabeth Kaegi, Director, Medical Affairs and Cancer Control, National Cancer Institute of Canada, summarized the ten steps used by the Canadian Cancer Society for program design and evaluation. These are based upon the premise that a specific behaviour is an important determinant of the cancer burden. Three sections address the ten steps. The first of these is the preparation which includes measuring the prevalence of the behaviour; determining why people engage in the behaviour, the priority audience and the social and physical environment that influences behaviour. Secondly, intervention selection and program design should allow for designing an effective program for behavioral change and pre-testing the intervention. Finally, delivery and evaluation includes determination of efficacy and effectiveness, as well as dissemination of the intervention and re-evaluation of the prevalence of the original behaviour.

Dr. Stephen Birch, Assistant Director, Centre for Health Economics and Policy Analysis, McMaster University, addressed some of the economic issues in cervical cancer screening. Using data from Hamilton-Wentworth in 1991, he demonstrated that there is a significant financial burden associated with the diagnosis of invasive cervical cancer. He outlined data from Sheffield, England, where an analysis of screening patterns in that population showed that 19% of the population was receiving 50% of the smears. A table of screening schedules and effectiveness was presented. The greatest number of cases prevented per 10^5 tests was 182.4 when screening was performed every 5 years between the ages of 25-64 years. The greatest percentage reduction in rate was achieved (93.3%) when screening was performed every year between the ages of 25-64 years. Various models were reviewed but the point was made that the most significant factor is that women still are not being screened. If the purpose of screening is to identify those women with cancer of the cervix, then the message would be more consistent if the system rewarded those providers who have best screened the population at risk. Incentive payments to the providers would best impart the appropriate message.

The national infrastructure to support health program development was clearly articulated by Ms. Sue Hicks, Assistant Deputy Minister, Healthy Public Policy Programs Division, Manitoba Health. The Conference of Health Ministers, the Conference of Deputy Ministers and the Federal/Provincial/Territorial Advisory Committees are responsible for setting priorities for program development at a national level. Criteria used for this include national significance, impact, common direction, capacity, return on investment and flexibility. Programs of screening would be implemented at a provincial level.

The forum was provided with a statement of the orientation, mandate, objectives and current priorities of the Women's Health Bureau by Ms. Abby Hoffman, Director General, Women's Health Bureau. The primary objectives are to enhance the responsiveness of Health Canada and the Canadian health system to the health needs and concerns of women to improve the lifelong health status of Canadian women. It was pointed out that to date, cervical cancer screening has not been visibly identified as an issue amongst Canadian women. This could be influenced by the Women's Health Bureau.

Dr. Heather Bryant, Director, Alberta Program for the Early Detection of Breast Cancer, Alberta Cancer Board, addressed the area of recruitment by drawing from the experience in breast cancer screening at a provincial level (Alberta). A direct comparison was discouraged as the target population for breast screening (ages 50-69 years) is an older population than that for cervical cancer. Furthermore, studies have identified different barriers to screening for each of these diseases, for breast cancer screening, barriers include fear, lack of knowledge, cost and lack of insurance, whereas for cervical cancer screening, embarrassment, fear, cost, lack of insurance, pain and procrastination are reported. Strategies for recruitment into the breast screening program were reviewed including the use of a mobile program with significant improvements in the level of knowledge and beliefs about screening as well as screening rates amongst the target population. Dr. Bryant concluded by emphasizing the need to identify the target population and develop a women-centred focus for recruitment strategies.

Dr. Terry Colgan, Department of Pathology, reviewed the issues of quality improvement and assurance in the laboratory. Formal proficiency testing programs exist in Ontario and Nova Scotia and have published results of this process. False negative rates for cervical cytology remain an important consideration. The Canadian Society of Cytology has defined this as the number of undetected positives divided by the total number of positives. Automated cytology screening systems may play a role in decreasing this rate although further evaluation of this technology is required before general application is recommended.

Information systems form an integral component of the Victorian Cervical Cytology Registry as described by Dr. Heather Mitchell. A successful registry must have the characteristics of integrity, utility, simplicity and quality. The functions of such would include a follow-up mechanism for women requiring intervention, a source for reminder letters to women and physicians, a personal cytology history, quality assurance, a source of data for developing policy, a research database and the provision of statistical reports. This will require effective consultation with community groups, professional organizations, consumers and political representatives.

Policy Development and Screening for Cancer of the Cervix

Despite the fact that there are provincial/territorial differences related to delivery of health services, upon comparison of the outcomes of the various working group sessions, some policy concerns emerged which were common to all working groups. Indeed, working group discussions suggested that from a policy development perspective, there are a number of essential components to elicit support for comprehensive cervical screening programs. These components include the right kind of information about the economic, social, and health burden of cancer of the cervix, to engender a broad base of support, both public and legislative, for creating the appropriate policy and regulatory context.

A. Information: What Policy Makers and the Public Need to Know to Support Comprehensive Cervical Screening Programs

Although there has been support amongst the academic, scientific, and medical communities for cervical screening programs since the initial Walton Report of 1976, there are still, in 1995, no comprehensive cervical screening programs in this country. Although there is scientific evidence to support the development of these programs, working groups noted the need for easy-to-understand, well-presented information that could be passed on to provincial policy makers and that clearly justify these programs in terms of both clinical and cost effectiveness. The information would be packaged in an appropriate context for easy and evident decision-making. Suggestions of the factors which would be important to note included:

(i) Population Health Perspective

In the past number of years, provincial health reforms have been designed to support and reflect a population health approach to health strategies. A population health approach differs from traditional health care thinking in that:

- it addresses the broad range of health determinants. Traditional health care focuses on risks and clinical factors related to particular diseases.
- it is designed to affect the entire population and stress preventive measures. Traditional health care deals with individuals one at a time, usually individuals who already have a health problem or are at significant risk of developing one.

For an organized comprehensive screening program for cancer of the cervix to receive support from those reforming the health care system, it needs to be placed within this context. Once, this has been done, the potential for gains can be shown in the health status, cost-effectiveness, and quality of care arenas.

(ii) Burden of Disease and Cost Implication

Cervical cancer is not only preventable, but is detectable at an early stage. In a perfect world, there ought not to be any deaths due to cervical cancer. In this country, there are about 400 deaths due to cancer of the cervix per year. However, the burden of the disease is much greater as its calculation would include treatment for women at various other stages of the disease which can be expensive for the health care system and for the patient. Indeed, the evidence that screening prevents the development of invasive cancer of the cervix and that this early intervention will be less expensive than treatment for a late-diagnosed cancer needs to be highlighted. Information about the relative costs of management on different protocols is needed in order to convince provincial governments to move forward on this issue.

Since the workshop *and in response to requests for an analysis of the costs of a comprehensive cervical screening, Health Canada has commissioned a report which would outline the current diagnostic and treatment cost burden of opportunistic screening for cancer of the cervix and compare this to the anticipated costs of a comprehensive cervical screening program. It is expected that the analysis will show that no new funds will be needed for a cervical screening program and that millions could be saved. It should be ready in early 1996.*

Furthermore, evidence of cost-effectiveness, cost benefits, decreased mortality rate and decreased societal costs are imperative to convince Health Ministers, funders and other senior officials to create screening programs.

Many of the working groups felt that comprehensive screening programs would not cost extra money. They felt that it was more a matter of redistributing existing funds and using them more effectively. Savings achieved by decreasing unnecessary screening would be used to offset the cost of increased screening in the previously under-screened groups.

(iii) Public Pressure: Champions, Advocates and Public Awareness

The working groups agreed that it was unlikely that the government would move forward on this issue without adequate pressure. Even with the available strong evidence, it was felt that without public pressure, the government would fail to respond. Indeed, public pressure has proven effective in the advancement of other causes - most notably AIDS and breast cancer - and would probably be a catalytic factor. Activities such as strong women's groups working with different medical and health care groups, a public letter writing campaign to the Minister, a visible "champion" for the cause, and having the community create public demand would be invaluable. This feeling was mitigated by an understanding that mobilization of the

public must be preceded by an understanding of the feasibility of comprehensive cervical screening programs and the benefits of these screening programs to the individual. Therefore, a two-pronged approach to the provision of information and a public awareness campaign on the benefits of screening probably need to precede a public pressure campaign. As it stands now, participants noted that

- some women think that screening is for sexually transmitted diseases only and not for cancer.
- some women do not know that they can ask their physicians for Pap smears, and that they do not have to wait until it is offered.
- some women do not know who is susceptible to cervical cancer and do not understand the risk factors for this disease.

B. Partnerships: Inter-agency, allied health professionals, public and private sector

The development of comprehensive cervical screening programs does not imply the development of stand-alone provincially-based physical infrastructures. Unlike screening for breast cancer, screening for cancer of the cervix is a low technology, low-cost procedure. However, a comprehensive cervical screening program does imply co-ordination of the preventive, diagnostic and treatment aspects of cervical cancer. As such, the linkages and partnerships that must be forged for a program to be successful are multi-disciplinary. These include provincial funding agencies; community-based family physicians; specialists; other health care providers such as nurse practitioners in rural areas and elsewhere and laboratory facilities and practitioners. Lessons can be learned from other disease areas, such as AIDS and other STDs, and from programs in other provinces and other countries. Partnerships, collaborative practices and coordinated activity must be actively sought out as they will probably not form naturally.

As a result, as the working group from Nova Scotia/Newfoundland pointed out, there is a demonstrated *need for leadership*. In their view, this entails coordinating the various agencies and ensuring adequate funding exists for the screening program. Leadership and involvement need not only occur at the federal/provincial level. It could include the non-governmental as well as corporate levels. Corporations that employ many women could aid in the promotion of screening programs for the prevention of cervical cancer. The working group from Saskatchewan and the Northwest Territories suggested that a coalition including the district health boards be formed to address the issue. Manitoba and Ontario suggested that the inclusion of the private sector, especially where there were private laboratories providing service, would not be out of the question. However, this working group also pointed out that with the development of partnerships comes *shared responsibility and shared accountability.*

C. Quality of Care: The Global Perspective

***Since the workshop** a multi- disciplinary group has formed which is being to explore tackling the issue of quality improvement and standard practices from a national perspective at all stages of care - from prevention to diagnosis and treatment.*

The participants felt that a plenary discussion on quality improvement would be more productive than individual discussion groups. In the plenary session, it quickly become obvious that a global approach to quality improvement and quality of care was necessary. The issue of quality control in the laboratory setting is a major component of a quality improvement program and it has been addressed to some extent in most provinces. However, other steps in the process, from smear taking to treatment and follow-up decision, need to be subjected to evaluation and monitoring.

Specifically noted in other working group sessions, was that there is a need for standard treatment protocols to be adopted upon diagnosis and that these protocols need to be adapted to the availability of local services. The Nova Scotia/Newfoundland group felt that, there is no point identifying people with CIN II and III with no one to treat them This idea was reiterated, although with a slightly different perspective by a delegate in the British Columbia/Alberta working group when discussing impediments to screening: when abnormalities or false positives appear, women may go through months of anxiety while waiting for follow-up. In general, the lack of guidelines and national standards are obstacles as verbalized by other participants. Consequently, screening and treatment variation between clinicians becomes a concern. Finally, the need for a national registry to facilitate a standardized approach was reiterated.

D. Enabling Legislation and Confidentiality

A core function of any cervical cancer screening information system is the ability to follow-up and recall women into the cervical screening program. However, the ability to develop registries is mitigated by the current regulatory and legislative conditions in each province. The Saskatchewan and the Northwest Territories working group felt that is imperative to have a clear understanding of what current legislation does and does not allow. This understanding will enable individuals to know what changes are needed and to focus on the necessary steps to be taken before a registry can be established.

According to participants from Saskatchewan, it is likely that changes to the Health Act would be needed to create a registry. Moreover, focus groups already held in Saskatchewan have indicated that women would not be averse to a registry. Saskatchewan has had past successes in this field, for example, the tuberculosis registry. Currently, rules and regulations are not in place for a cervical cancer registry, but people are working on the principles involved in the creation of one. The ideas of informed consent, personalized and non-personalized data, ownership of data, and procedures for data release are topics that are being examined.

Equally, participants noted that the Northwest Territories probably already has adequate legislation as they currently collect information on suspect cancers and pre-malignancies. In the Northwest Territories, there is concern over confidentiality but it is often not vocalized. The repercussions resulting from breaches in confidentiality are serious, as the area's small population allows many of the residents to know one another. As well, many communities associate some diseases with stigmas. Care must be taken in the collection and dissemination of medical information. Yet, the Legislative Assembly of the Northwest Territories has decided that knowledge about the health of its residents is a right of the community. Failing to provide this information is a "breach of moral ethics". A delicate balance exists between the rights of the individual and that of the community, which must somehow be maintained in an area where suspicion over confidentiality already exists.

Participants from Manitoba noted that the Manitoba Cancer Act would need to be changed to allow for a registry. Issues to be addressed would include access & confidentiality involved with database sharing, and the inclusion of non-malignancies in addition to malignant cases.

The possibility that patient confidentiality is of a greater concern "for us than the general public" was discussed by the participants from Ontario. It is likely that with the advent of the Internet and the fear of the rise of private health insurance plans, the anxiety regarding breaches of confidentiality may increase. Furthermore, Ontario's privacy and confidentiality laws are contained within 77 statutes. Ontario does have a Cancer Act, which only covers malignancies. Additional legislation or amended legislation may be needed to cover a registry. Legal advice is currently being sought in this area.

Only the participants from Nova Scotia Gynaecological Cancer Screening Programme were aware that provincial legislation does exist which requests laboratories to report information to the Cytology Registry. There, the patient's consent to this information sharing is implicit in their request for a Pap smear. To date, they have not received any complaints. The Newfoundland Cancer Foundation are addressing the legal implications for physicians.

Although enabling legislation does not exist in British Columbia or Alberta, the participants in that working group did not feel that it would be difficult to obtain. Before requesting legislation, one must be certain that what is wanted is clearly articulated. When a similar process was used with the Alberta Program for the Early Detection of Breast Cancer, it was revealed that legislation was not needed. The Breast Cancer Registry exists without legislation. Other areas of concern were the exact definitions of "consent" and "confidentiality" and whether those in charge of information systems could be trusted to release the information appropriately. However, the participants of this working group did add that they felt it was imperative that women know to what they are consenting, i.e., that it be made explicit. Are women giving their permission for personal data to be contained in the registry only for recall, follow-up and program evaluation activities or are they consenting to be part of potential research projects?

Implementation of a Comprehensive Cervical Cancer Screening Program: Specific Issues

Despite the common nature of the concerns, issues, and challenges that face each of the provinces and territories, each province/territory operates the delivery of health care services within a slightly different context. As such, the discussions within the working groups often provided a slightly different focus. Despite this, there were commonalities in the types of implementation concerns discussed. Where appropriate, the working group is identified.

A. Recruitment:

As the groundwork for a comprehensive cervical screening program is being developed and implemented, strategies for recruiting and maintaining a high level of physician and patient participation will be key. A number of good suggestions were brought forward. For instance, one suggested strategy involves having physicians recruit their patients. Some groups noted that there might be some challenges in terms of a reticence on the part of patients to have male physicians doing the smears. Nonetheless, physicians encouraging participation in preventive behaviours in general and recruitment into screening programs, specifically, is known to be an effective method of increasing screening rates.

Action Taken Since the Workshop: *A report commissioned by Health Canada is in print. The report,* ***Barriers to Screening: A Critical Review of the Literature (1990-1995),*** *elucidates some of the documented physician and patient barriers to participating in preventive screening practices.*

A study in Northeastern Ontario is being supported by Health Canada, looking at the knowledge, attitudes and barriers to cervical cancer screening amongst grade 9 students.

Another method suggested by a number of working groups was that of "piggy-backing" or linking cervical cancer screening with breast cancer screening. While this would not capture the entire target population for cervical screening, it would solve the problem of initially finding participants. However, as noted in many of the working groups, this suggestion might create more problems than it solves, in that the screening intervals for breast and cervical screening are different and women would not be encouraged to develop a relationship with their personal health care provider.

Another suggested strategy from the Quebec, New Brunswick and Prince Edward Island working group and the Nova Scotia and Newfoundland group was to provide health status reports by region. If individuals in a community knew their region had an above average rate of disease, they might be prompted to take preventive measures, including screening. A second suggestion focussed on physicians. In New Brunswick, supplies are provided to

physicians (spatulas, etc.). Quebec would like to see this occur within its borders as well. Laboratories could also assist in this process by educating physicians on the appropriate use of the equipment.

Regardless of which recruitment strategies are utilized, all working groups cautioned that there are certain considerations that must remain in the forefront of program directors. Some barriers identified by multiple groups include embarrassment, fear of diagnosis and fear of sexual assault. Suggested means of identifying recruitment barriers included focus groups and surveys on the premise that the best way to determine why women were not participating was to ask them. Recruitment strategies would need to target specific sub-groups such as rural, immigrant, older, or Aboriginal women. Women may be informed, via posters hanging in doctors' offices, about Pap smears (or other preventive health measures) that may be performed during a visit to the physician. Other suggestions include an information session on cervical cancer and Pap smears in health information presented to females in junior high school and the inclusion of information in child tax credit mailings.

The Ontario/Manitoba group suggested that recruitment activities be fashioned to be cost-effective; i.e., the costs of advertising and recruitment must reflect the additional women brought into the system as a direct result. Furthermore, the working group from British Columbia and Alberta suggested that any proposed recruitment strategies "respect the autonomy of individual women". Thus, having a Pap smear must not become a personal burden to the woman and must be facilitated though current structures in place. For instance, successful initiation into the cervical screening program might be accomplished through the incorporation of Pap smears into immigration medical examinations for new Canadians and as part of the entrance examination into a nursing home for seniors.

A wide range of responses to the strategies for the development of and for recruiting women into these programs will be displayed by partners and participants and the programs must be ready to accept them, deal with them effectively, and learn how to avoid them. For instance, when dealing with some communities, there is a protocol to follow in order to ensure participation, e.g., when contacting Aboriginal communities in Northern Saskatchewan, the Tribal Councils are the first community members to be approached. Recruitment strategies in the Northwest Territories must include community nurses as active participants as many are in-charge of the health centres, an important aspect of health services. Language and cultural sensitivity are not new or unique considerations but are nonetheless important. In Australia, it was acceptable to send out letters in English only; in the Northwest Territories, all 8 official languages must be used. These factors must be taken into consideration and incorporated into any recruitment strategy.

B. Periodicity and Acceptable Rates for Screening

The question of the appropriate periodicity for screening for cancer of the cervix elicited a variety of comments from the different working groups. Fundamentally, people did not disagree with the recommendations from the 1989 workshop. However, since 1989 recommendations come as an interdependent-bundle, discussions touched on what to do in the interim.

Discussion around acceptable rates for screening elicited a wide variety of opinions. The working group for British Columbia and Alberta commented that a province must decide if they wish to set challenging goals, or ones that are easily attainable. These goals can be set scientifically, but one must remember that there are also political and ethical factors that influence this decision. Indeed, the working group from Manitoba and Ontario suggested that the words "acceptable rate" were contentious. They feel that "target rate" is a more appropriate term. Programs should be striving to reach optimum goals, which will change over time. A single "acceptable rate" is not realistic. There will be many different goals, reflecting the province's different populations, that will incrementally increase until all women receive screening.

The Quebec, New Brunswick and Prince Edward Island working group advised that it is very difficult to set a screening rate for cervical cancer. Unlike breast cancer, where it is known that 70% of women must be enrolled before an impact on mortality is seen, there is no such target number in cervical cancer screening. It is known that invasive cervical cancer is more prevalent in women who do not receive regular screening: deciding on 70 or 80% as the acceptable screening rate would be completely arbitrary. It would be quite possible that the greatest cancer incidence would be in the 20-30% of women that were not screened.

C. Support from Health Care Providers

Without the support of the provider community, a comprehensive cervical screening program will not operate at an optimal level. In all likelihood, participation in these preventive screening programs will be voluntary. Hence, support from the broad range of health care providers for an organized comprehensive cervical screening program is essential. For optimal coverage, there needs to be appropriate training and educational support to physicians as well as, at the very least, no financial disincentives to participate and preferably financial incentives to participate. Training and educational incentives would encompass not only educational information about the appropriate periodicity, treatment protocols, and various administrative components to the programs but might also instruct on how to reach high-risk and hard-to-reach women. Furthermore, it would encompass continuing education on the mechanics of taking the Pap smear.

The group from Saskatchewan and the Northwest Territories felt that health care practitioner support is very dependent on the provider's awareness. The experience of participants from Saskatchewan is that their physicians like follow-up systems. However, while they feel physicians would support a recruitment program, their experience to date with information systems has made physicians sceptics of what they perceive to be "outside agency" control of an aspect of health care. Furthermore, Saskatchewan physicians have questioned the need for some of the information that laboratories collect. It was therefore suggested that in order to elicit physician support for a cervical screening program, quality assurance, recall, and information systems be approached from an educational perspective. If physician samples were compared to the norm, and were found to be below average, the physician would be motivated to raise their rates to normal levels. Another motivational factor for physicians would be providing women with report information about their smears including adequacy. Regardless of the decision, physicians concerns must be alleviated by allowing them the opportunity to participate in the decision making process.

In the Manitoba and Ontario group concerns revolved around the issue of how the data about the smear would be shared. Some physicians feel that they "own" this information. Laboratories may have concerns about releasing data to a shared database. Furthermore, legislation so that medical records systems can send certain specific information to a central registry does not exist. Without resolving these issues, it might be difficult to elicit broad-based physician support.

The Nova Scotia/Newfoundland and Quebec, New Brunswick, and Prince Edward Island working groups felt that physician support should not be that difficult to develop as intuitively physicians realize that organized screening is better for the patient and themselves. Indeed, in Nova Scotia, lack of support for the existing program is not an issue. However, much support and information is provided to health care practitioners to facilitate their participation. Support in Nova Scotia is a "two way street".

The Role of Government

Underlying each discussion at the workshop was the question of who would take the initiative and the responsibility for undertaking the activities necessary for the development of comprehensive cervical screening programs. By its very nature as a population screening tool, governments (federal, provincial and territorial) have a large role to play. Through the tenets of the Canada Health Act (1984), the federal government is responsible for ensuring public administration, comprehensiveness, universality, portability, and accessibility of the different provincial health care services. The provinces and territories are responsible for the design, implementation and management of their own health care services. Notwithstanding this role delineation, it is widely recognized that future improvements in the quality and effectiveness of health care services will require cooperation between a multiplicity of partners including federal, provincial and territorial governments, health professionals, voluntary and non-governmental organizations as well as individual Canadians.

In order to elicit participants' understanding of and suggestions for the proper role which governments could play in the development of comprehensive cervical cancer screening programs, each working group session concluded with a discussion of this very topic in relation to the theme in question. Across the working groups, the discussions depicted the federal government in the role of coordinator and facilitator and the provincial governments as "champions", financiers, and legal scrutineer. Specifically, five key areas were defined: information exchange and networking, standard and guideline development, information system and registry development, recruitment and public awareness, and delivery of services.

A. Information Exchange and Networking:

Under the five principles of the Canada Health Act, an important role that the federal government can play is in the facilitation of information exchange and experiences, the creation of interprovincial linkages, and the creation of joint programs and approaches to the development of comprehensive cervical screening programs. This can be done through a variety of mechanisms including workshops, national working groups, collation of research findings, and electronic networking, to name but a few. Providing international and national statistics of relevance to the provincial program developers as well as collating the research and knowledge gained to date and disseminating it to the provinces is another means available to the federal government. Furthermore, the federal government is best positioned to identify the multidisciplinarity of legitimate stakeholders that ought to be involved in the resolution of issues surrounding the development of comprehensive cervical screening programs. To give an example, with respect to immigrants, the federal government could be of further assistance by conducting a symposium on immigration and health, using a screening process in immigration and directing new immigrants to prevention programs. Furthermore, the federal government may also be the link to aboriginal women with the provinces in an effort to target under-served groups.

B. Quality of Care

The federal government has a clear role to play with the development of clinical practice guidelines. In an effort to achieve uniformity of care across the country, the federal government can lead the stakeholders in an effort to forge consensus on controversial issues related to cervical screening. Just two examples are periodicity and treatment protocols for abnormal smears. Agreement needs to be reached on how the patient ought to be treated for purposes of quality of care and costliness of care. There is also a need to have clear guidelines for laboratory practices as well as standardize the terminology in use for laboratory tests. Accreditation procedures must be clear and actively monitored by the accrediting body. Other examples include the development of a means of measuring and improving the quality of the smear taken by the physician and a means for the individual physician to receive feedback on the adequacy of his/her smears. This type of initiative might be taken at the federal, provincial/territorial and non-governmental levels. Professional groups should be encouraged to take a leadership role in this regard.

C. Information Systems and Registry Development

A recurring theme during the workshop was the need for a population-based information system. The participants at the workshop see the federal government's role in establishing such a system as including any or all of the following tasks:

- Conducting a follow-up workshop on information systems. Topics to discuss could include user requirements, data release policies, standards and jurisdictions regarding access to the information, and standardized terminology.
- Creating a working group responsible for developing systems which can aggregate data nationally.
- Conducting pilot studies and feasibility studies.
- Ensuring the implementation of an evaluation plan which would compare baseline data to data acquired post program implementation.

A comprehensive cervical screening program would be greatly enhanced by information systems compatible between provinces. This is an issue that must be addressed by the Deputy Ministers.

The role of the provincial/territorial governments was seen as at the regulatory, and financial levels. The review and revision of legislation in order to facilitate the development of information systems was seen as essential. In addition, the support of pilot and feasibility studies was also seen as important. The support of provincial epidemiologists for provincial registries, would reinforce their need in the eyes of provincial governments and facilitate their development.

D. Recruitment and Public Awareness

The two levels of government need to work in tandem to raise public awareness, mount social marketing campaigns, provide funding for start-up and operating costs, and stimulate private and public laboratories to participate in a comprehensive cervical screening program, as it is doubtful that a new infrastructure will be set up for cervical screening programs. It is essential to have women interested and involved in the development of a comprehensive program. As a result, partnerships with non-government organizations need to be formed. One group suggested raising public awareness (working in conjunction with non-government organizations) by contacting the media, running "come to our clinic" campaigns, training volunteers to do outreach, having speakers from women's groups and promoting the participation of women. Once a recruitment plan is ready to be undertaken, the provincial government could enhance its success by promoting cervical cancer screening to physicians as well as facilitating communication between provincial stakeholders.

E. Delivery of Screening Procedures

In order to sustain interest and generate the political will for the development of a comprehensive cervical screening program, work needs to be done promoting the economic viability of such programs. Furthermore, the provincial governments may also be in the best position to create provincial working groups to examine all aspects of comprehensive cervical cancer screening especially, the links between information systems, recruitment, public awareness, service delivery, and patient navigation of the health system.

Financial assistance might be made available by the provinces for provincial working groups, including grants to initiate the program and set-up an information system, and fee schedule adjustment to encourage participation in the screening programs. Fundraising through a third party might be an option.

Provincial Action Plans

The final day of the workshop was devoted to "getting from here to there." Participants from each province were asked how they felt they could move the issue forward and catalyze activities in support of comprehensive cervical screening in their province or territory. Each group came forward with an action plan. In order to fully comprehend these actions plans, you will find below a table of the elements already in place which participants found to be crucial to the development of a comprehensive program. Following this, you will find each provinces' action plans. Please note that these action plans are at different stages of development as some provinces' have well established programs, while in others comprehensive cervical cancer screening is in its infancy. Please also note that these action plans reflect only the intended actions of the participants of the workshop and did not denote a firm commitment of time or resources, although there was obvious enthusiasm and renewed motivation to carry through the action plans.

Key Elements For A Comprehensive Cervical Screening Program Already in Place

British Columbia

Although British Columbia has an opportunistic rather than comprehensive cervical screening program it does have a number of the elements of a comprehensive program already in place. An information system is currently in place as are goals, objectives, priorities, audience, standards, quality assurance . There is a recall system although it is of questionable effectiveness with Aboriginal women and recent immigrants. In addition, integration with follow-up systems is in place. There is an evaluation of the program however, it does not encompass detailed economic data.

Alberta

Alberta has an opportunistic rather than comprehensive cervical cancer screening program. They do not have any information systems, nor do they have clear goals, objectives, priorities, audience, standards, or quality assurance practices or call/recall practices, but participants felt that they had the necessary skills within Alberta to pull it all together should a catalyst for action be found.

The Northwest Territories

The Northwest Territories partly depends on service from British Columbia and Manitoba. In the Northwest Territories, trained nurses perform 80% of Pap smears. It is hard to get information from many Yellowknife physicians.After the 1989 workshop, the Northwest Territories program developed there are some limitations on quality assurance because while initial screening is done at the same lab, subsequent follow-ups can be done anywhere. The disease registry which requires the recording of malignant diseases can be of use. As well, the Hospital Insurance Act allows information to be released to bona fide researchers, and this can be of use. The Public Health Act is presently under revision and missing elements can be built into the Act. The sparse and "captive" population is an advantage in identifying clients.

Saskatchewan

Saskatchewan has an advanced health information system. There is a fairly good quality assurance practices, but it needs improvement.There is good follow-up for people in the registry but if women have not entered the system, there is no recall for them. The two databases are not as yet linked. Linking the data bases means linking the two provincial labs. There is a feedback mechanism, but it doesn't track physicians over time and is not very comprehensive. The recommendations from the 1989 conference have been a strong impetus. The province has implemented the 25,000 lab limit, the recommendation for three full-time workers, and has started on centralization. The cervical cancer program can piggy-back on other established programs, such as the breast cancer program.

Manitoba

Manitoba does not have an organized program but does have some pieces, e.g. commitment at the government level and professional impetus, but lacks a mechanism to ensure implementation. There is a provincial committee looking at the issue of a comprehensive screening program . It is a cross-sectional committee, initiated by the health department.

Ontario

Ontario has leadership and commitment, both at government and professional levels. It has an ad hoc working group looking at developing the key elements for a comprehensive screening program. It has made some initial movement, e.g. recommendation for a centralized population-based data base.

Quebec

Quebec has no central registry; cytology is interpreted at university hospitals. There are no guidelines in place and no way of monitoring quality assurance.

New Brunswick

New Brunswick has well established quality assurance within labs and a working committee of obstetricians and gynaecologists for quality control. There is no central registry or laboratory (the province has eight regional laboratories) and no monitoring/evaluation. The impetus is the laboratories' commitment to quality, plus most laboratories are located in hospitals. The province follows the American guidelines and has received accreditation by the American Pathologist Association.

Nova Scotia

Nova Scotia has a cervical screening program which has the leadership, legislative clearance, public and professional education strategy as well as an information system that is currently under development. A recruitment strategy will be pursued this coming year.

Prince Edward Island

Prince Edward Island has quality assurance guidelines, a central registry and clear guidelines & is working on a computer database for follow-ups. Monitoring/evaluation are not yet in place. The impetus to ensure quality assurance is professionals' commitment, and the fact that only one lab exists so there are no variations in quality. The province's small size is also helpful and it has received accreditation by the American Pathologist Association.

Newfoundland

Newfoundland has an information system, but no educational campaign. It has legislation, but reporting information is not mandatory.

British Columbia

The British Columbia Cancer Agency is in the process of introducing a new computerized cytology information system for the B.C. Gynaecological Cytology Screening Program. The new system is expected to be fully operational by the end of June 1995. It will allow them to expand their Quality Assurance Program in the laboratory and to establish a call-recall system giving priority to older and infrequently screened women in the first instance. In addition, the new information system will allow much greater access to data in the information system for approved individuals conducting epidemiological and statistical studies.

Alberta

The first step for Alberta is to approach the Minister of Health and obtain a formal request for the development of a comprehensive cervical cancer screening proposal. To achieve support, it might be necessary to lobby for support. Once this is accomplished there will be a need to identify a working group and/or a champion. The group's responsibilities will include establishing a mandate, ensuring the participation of stakeholders, developing goals and objectives, reviewing other programs (e.g., the breast cancer model) and fostering inter-provincial contact. The latter can only be accomplished in collaboration with the federal government (Health Canada) to ensure national network/links are in place.

Once the process is defined, a proposal could be developed through a `community' process, (with support from Minister) by October 1995, for implementation by April, 1996. The proposal will have the following:

- a rationale explaining a comprehensive cervical cancer screening program and how it fits with the restructuring of the health care system
- a consultation plan
- a section on steps to increase buy-in along the way (Interest groups, NGOs: connect with regional board, Alberta Cancer Board (ACB), CCS, consumer representatives, professional groups, breast cancer program representative),
- linkage with breast cancer issues

While the proposal is being developed, the Deputy Ministers of Health can be approached to review provincial legislation, and ask that the Canadian Institute for Health Information review minimum data set core transfer of information. There should be contact with organizations like the Canadian Bar Association, to review the need for new legislation.

The Northwest Territories

In the Northwest Territories the first step is to hold a meeting with departmental officials to ensure that the fragmentation of data from the program is corrected. Once it is clear that this "fragmented data" is a hindrance to an effective program, then corrective measures can be put in place to rectify the flaws in the system. One example is the turn-around times for smear results: in order to remedy this problem, the cause for the delays has to be identified.

The next step will be to create patient, provider, and community/population-based profiles of the program's coverage. For example, not only is there a need for appropriate analysis to demonstrate that older women are not being screened, and that over-screening is occurring, but where and why this is happening.

Saskatchewan

Saskatchewan Health wants evidence that a comprehensive cervical cancer screening program is necessary. Once this is accomplished, Saskatchewan will hold a stakeholders' meeting to discuss the issues. Stakeholders could include various levels of government, women's groups, the College of Physicians and Surgeons, laboratories, and technicians.

Optimally, a task force (initiated by the Minister of Health) would be created to implement recommendations tabled by the commission. Saskatchewan has been implementing many of the recommendations of the 1989 conference but it has all been fragmented. A united effort would provide Saskatchewan with a strong impetus.

Lobby groups could be formed by women's groups, laboratories which are looking for funding, the Cancer Foundation, obstetric/gynaecology physician groups and epidemiologists.

The program could eventually be coordinated under the auspices of the Cancer Foundation, as a precedent has been set with the breast cancer screening program.

Finding a "champion" for the cause is an important step because without a strong advocate, there is a tendency for nothing to happen. However, recent experiences at the local level has also shown that it can be difficult to work with a champion. If a champion doesn't step forward, medical health officers within districts, the provincial health council, or people who report directly to cabinet should be scrutinized as potential champions.

There is also a need to develop a strong information system and to cultivate media attention to get the message across to legislators, medical/health care groups and the general public. One way is for articles to be written for inclusion in a variety of pertinent newsletters.

Manitoba

In the last few months, the Manitoba Cancer Foundation has convened a committee to look into the organization of a more complete mass screening program for cervical cancer; this committee will look into better ways of making women of Manitoba more aware and willing to participate in screening for cervical cancer.

This effort will particularly encourage participation from certain segments of the female population (Aboriginal women, older women and prostitutes).

The committee in cooperation with the College of Physicians and Surgeons of Manitoba will also support closer adherence to Quality Assurance guidelines for the practice of cytology in Manitoba.

In addition to the above, the Provincial Committee for Laboratory Medicine after a year's deliberation has recently (1995) issued their report advocating the amalgamation of Cytology Laboratories (both public and private) into fewer but larger units for better efficiency of the screening program as well as the formation of a central Cytology Registry.

The actual implementation of the recommendations of the Provincial Laboratory Medicine Committee has not taken place yet.

Ontario

The Cervical Screening Ad Hoc Working Group was formed in October 1993 by the Ontario Cancer Treatment and Research Foundation, the Ontario Medical Association, and the Ontario Association of Medical Laboratories. The aim of the Group was to improve cervical screening services in Ontario. The Provincial Cancer Network, which was formed by the Ministry of Health in April 1994, asked the Working Group, which now consists of many other key stakeholders, to prepare an implementation plan for a cervical screening program for Ontario. This was submitted in December 1994. The following action plan was proposed.

Obtain formal recognition by the Ministry of Health of the Cervical Screening Ad Hoc Working Group. Initiate community-based pilot projects on information systems for cervical screening and for cervical smears in six non-hospital laboratories. Pilot studies on methods to recruit women to screening programs were also required as were guidelines on screening intervals after normal smears and the management of abnormal smears. A subgroup should be established to review new technologies in taking and reading of cervical smears.

Quebec

The first steps to building a comprehensive cervical cancer screening program include using money more efficiently and establishing an administrative group to coordinate cervical cancer initiatives and stakeholders.

Once this is accomplished, the process for implementing programs for breast cancer and cervical cancer will be compared. At present the public health department of the Ministry of Health is responsible for implementing breast cancer initiatives.

In Quebec, professionals have formed a Cancer Council to monitor the situation. There is a sub-committee devoted to screening, comprised of women's groups, cytologists, and gynaecologists among other stakeholders. Other sub-committees monitor diagnosis, rehabilitation and support, among other issues.

Quebec will also raise awareness about cervical cancer.

New Brunswick

The Deputy Minister will be approached to identify a responsibility centre. Once a responsibility centre has been established, a stakeholders meeting will be held. A cytology registry will be established; it will be monitored by an epidemiology unit.

The Health Ministry is well positioned to facilitate discussion with the Medical Society regarding education, recruitment, and quality control.

Nova Scotia

The next step to be initiated will be to develop recruitment strategies which will include conducting behavioral research, identifying individuals comprising the unscreened and under-screened populations and conducting a regional pilot project targeting the unscreened population.

In addition, a process of reminder letters to physicians with respect to women with abnormal results who have not been re-screened within a given period of time as well as "recall" letters to women who have "lapsed" from the program will be established.

As part of the quality assurance program of pathology, cytology and colposcopy, there is now a regional pilot project to evaluate the quality of smears.

At present, the province is in the process of sharing the successes and failures of developing an information system to meet registry needs with other provinces. This is more efficient than "reinventing the wheel." In addition, an external evaluation of programs currently in progress will be completed around June 1995. The first Annual Report will follow.

Prince Edward Island

In PEI, a working group has been in place for the last three years in order to turn the information currently available into a "usable" form. Hardware is being purchased to make information readily available. Within two months, a relational database will be initiated. Following the development of the database, it will be possible to know who has been getting smears, and who hasn't. Screening rates will be easy to monitor.

PEI will focus on asking physicians to recruit women. If rates of cervical cancer don't decrease, then a direct message will be delivered to women. Physicians have to be provided with tools for follow-ups. Physicians are not keen on contacting women directly; 95% say that pap smears are part of routine check-ups. Actual numbers of those who are screened can not be generated, as there is no information system, but it is anticipated that 62% of women are not screened regularly.

Newfoundland

The first step in building a comprehensive cervical cancer screening is to organize a presentation with the provincial government to establish a provincial working group.

Once a provincial working group is created, the next step is to implement an action plan/critical path by establishing goals and objectives and create an evaluation framework. Further, linkages and upgrading information systems must be developed.

Appendix A
Laboratory Accreditation Procedures

BRITISH COLUMBIA

- **Who licenses laboratories in British Columbia?**

  Laboratories in British Columbia are licensed by the Ministry of Health.

- **Who accredits laboratories in British Columbia?**

  Accreditation is performed by pathologists and technologists under the auspices of the B.C. Association of Laboratory Physicians.

  The British Columbia School of Cytology is accredited separately by the Canadian Medical Association (CMA) accreditation process for technology schools.

  In addition, the laboratory is inspected at the time at which the entire Clinic is assessed by the CMA Hospital accreditation process.

- **What is the process by which labs are assessed for licensure?**

  Each of the three groups noted above have their own criteria which become more complex at each visit.

- **How often is accreditation reviewed?**

  One or other of the above accrediting bodies looks at the laboratory approximately every two years.

- **What are the implications of not being accredited?**

  This will vary according to the degree which the laboratory departs from accreditation standards. Accreditation is not meant to be a punitive process and failure to meet accreditation standards is usually satisfied by following the recommendations of the accrediting organization.

- **Is there a centralized laboratory for cervical smears?**

  The B.C. Cancer Agency has the only laboratory in British Columbia which is licensed to process and interpret cervical smears.

- **How do you ensure quality control on an on-going basis?**

  a. All technologists have their work reviewed on a regular basis each year.

  b. All overcalls, undercalls and misses are recorded for each cyto-technologist and pathologist.

c. At the time the first significant abnormal smear is detected in a patient with previous negative smears, the prior three smears are re-screened.

d. All significantly abnormal cervical biopsies are correlated with prior cytology.

e. A monthly Quality Control (QC) report is produced for each cytotechnologist and pathologist.

f. The laboratory participates in the Ontario LPTP (Laboratory Proficiency Testing Program) Cytology QC Program.

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YUKON

All cervical smears are sent to British Columbia for reading.

ALBERTA

The province is in the process of restructuring laboratory services, including governance, service and quality assurance. Although the information gathered is current at the time of printing, it may subsequently change.

- **Who licenses laboratories in Alberta?**

  In Alberta, hospital laboratories are licensed by Alberta Health, while private laboratories are licensed by the College of Physicians & Surgeons of Alberta.

- **Who accredits laboratories in Alberta?**

  Alberta Health has contracted the College of Physicians & Surgeons of Alberta to accredit hospital facilities on their behalf.

- **What is the process by which labs are assessed for licensure?**

  On-site inspections are done for accreditation. The College of Physicians & Surgeons of Alberta is currently revising questionnaires which are completed by the facility prior to inspection. Copies of questionnaires will be available as of June 1995.

- **How often is accreditation reviewed?**

  All laboratories are accredited at four year intervals unless problems identified in the interim would deem an early inspection necessary.

- **What are the implications of not being accredited?**

  Alberta Health is advised and payment for services is suspended.

- **Is there a centralized laboratory for cervical smears?**

  There is no centralization of services for cytology.

- **If not, where are cervical smears sent?/ # of laboratories?**

  Approximately 20 facilities, both public and private.

- **How do you ensure quality control on an on-going basis?**

  The medical director of each facility is responsible for the quality control in each individual facility. This is reviewed at the time of accreditation renewal every four years.

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NORTHWEST TERRITORIES

Cervical smears are not processed in laboratories of the Northwest Territories. A screening program is contracted through the British Columbia Cancer Agency for the whole of the Northwest Territories, with the exception of the City of Yellowknife. Diagnostic and screening smears from the Yellowknife area are sent to Hanson and Associates Laboratory in Edmonton, Alberta. Other diagnostic smears on Northwest Territories women are carried out in the contiguous provinces of Quebec, Ontario, Manitoba and British Columbia.

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SASKATCHEWAN

- **Who licenses laboratories in Saskatchewan?**

  Laboratories in Saskatchewan are licensed by the Department of Health.

  To obtain a licence, a lab must comply with Quality Assurance Standards as set out by the College of Physicians & Surgeons. The Department contracts with the College to set standards and monitor the quality of testing in laboratories. Thus, licensing system works hand-in-hand with the College of Physicians & Surgeons.

- **Who accredits laboratories in Saskatchewan?**

  The legislation which governs laboratories in the province is currently being revised to incorporate an accreditation process. It is anticipated that the regulations which give the College of Physicians & Surgeons Quality Assurance Program accrediting authority will be proclaimed this fall.

- **What is the process by which labs are assessed for licensure?**

  Licensing of laboratories (tests) will be dependent on a laboratory's accreditation status.

  The College of Physicians & Surgeons Laboratory Quality Assurance Program will be responsible for accrediting laboratories according but not limited to: quality assurance standards, qualifications of staff, external proficiency testing, equipment and facilities, testing methods and procedures, safety, remedial education, internal quality control and inspections.

- **How often is accreditation reviewed?**

  At this time, the quality assurance in laboratories is continually monitored. If laboratories fail to meet recognized quality assurance standards, the Department is notified.

  The laboratory licensing program was first established in 1989 as a combined process of licensing and accreditation under the authority of a Medical Laboratory Licensing Board. Since that time there have been significant changes to both the legislation and the assessment and evaluation of laboratory procedures and operations. Although the College has been monitoring the quality of testing and establishing standards since the program began, the accreditation program and process are still being developed.

- **What are the implications of not being accredited?**

  In Saskatchewan, laboratories are licensed by site and each lab is licensed to perform a list of tests. Quality Assurance deficiencies are identified by the College of Physicians & Surgeons Laboratory Quality Assurance Program. The College has a systematic method for addressing and dealing with these problems and works collaboratively with laboratories to correct deficiencies. If deficiencies continue to occur the College will notify the Department of Health and recommend a course of action. Options for the Department include: suspending a license or an individual test(s) until deficiencies can be corrected or revoking a license for a facility or an individual test(s).

- **Is there a centralized laboratory for cervical smears?**

  The province is moving towards centralizing cervical smears to two laboratories. This change is a result of recommendations from the Saskatchewan College of Physicians and Surgeons Cytology Quality Assurance Committee.

- **If not, where are cervical smears sent?/ # of laboratories?**

  Gynaecological cytology laboratory services in Saskatchewan are currently provided by laboratories based in four (4) licensed sites. Of these, two perform the bulk, while the remaining two perform small numbers of cytology procedures for their own hospitals.

  Intent for January 1, 1996: two (2) centralized sites, one for the Northern area and one for the southern region of Saskatchewan.

- **How is quality control ensured on an on-going basis?**

  In Saskatchewan, laboratories performing tests must subscribe to an external proficiency testing program. This includes laboratories performing gynaecological cytology screening.

  The external proficiency testing program, recognized as acceptable by the Saskatchewan College of Physicians & Surgeons Quality Assurance Program, is operated by the College of American Pathologists. Laboratories have been subscribing to this external proficiency testing program since 1990. All results of this program, with the exception of gynaecological cytology, are sent to the originating laboratory and the College's Quality Assurance Program. The results of gynaecological cytology are sent only to the originating laboratory.

  The College's Quality Assurance Program has requested cytology results from CAP also be sent for review by the accreditation program, however, CAP has declined these requests. CAP does not consider this an external proficiency testing program but an educational program and therefore is unwilling to send results to the College.

Since the issue of gynaecological cytology results has not been resolved with CAP, the College is currently evaluating options for other external proficiency testing programs. Options being evaluated include the Ontario Laboratory Proficiency Testing Program (LPTP), an internal provincial program as well as the possibility of developing a western program.

■ Additional information:

Several years ago laboratories performing cytology screening recognized the need to establish a process of ongoing education. In 1992, a provincial educational program was developed which consisted of case studies that circulate slides among the laboratories. For the past year, the College of Physicians & Surgeons' accreditation program has been receiving these results and are involved in developing an action plan for appropriate follow-up of abnormal results.

Recommendations of the Cytology Quality Assurance Committee: (approved by the Program Management Committee as policy November 1993).

1. Gynaecological cytology testing in Saskatchewan be centralized, ideally in 2 locations.

2. Until the above is achieved, labs with fewer than three qualified cytotechnologists or less than optimal volumes of workload be encouraged to associate with other labs to maintain adequate staffing levels, participate in educational and quality control activities and peer review or to refer all their work to a larger laboratory.

3. An external Quality Assurance Program for gynaecological cytology, be established in Saskatchewan as soon as possible to closely monitor the quality of testing and also to provide education and improve performance.

4. A common patient data base be established in Saskatchewan which is accessible to the labs and other users.

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MANITOBA

- **Who licenses laboratories in Manitoba?**

  Laboratories in Manitoba are not licensed; they are accredited.

  However, a license to operate a Cytology Laboratory is issued to the laboratory's Medical Director, who must be accepted by the College of Physicians and Surgeons of Manitoba as being properly qualified in laboratory medicine (by a fellowship in Anatomic Pathology, General Pathology, or equivalent). Applications for a license are reviewed by Manitoba Health (Standing Committee on Diagnostic Services) and the College of Physicians and Surgeons (Manitoba Quality Assurance Program).

- **Who accredits laboratories in Manitoba?**

  The Manitoba Quality Assurance Program under the auspices of the College of Physicians & Surgeons in Manitoba accredits all diagnostic facilities in Manitoba. This includes laboratories, diagnostic imaging and nuclear medicine facilities.

- **What is the process by which labs are assessed for licensure?**

  Once a facility is approved, it must apply for approval to perform procedures. The method of obtaining approval for additional or new procedures is two-fold: an application must be forwarded to the Manitoba Quality Assurance Program. MANQAP reviews the application and makes the decision based upon professional input, technical personnel, equipment, facility and quality control programs. An application must also be submitted to Manitoba Health who makes a decision regarding approval based upon the need for that particular procedure in that particular area.

- **How often is accreditation reviewed?**

  MANQAP attempts to perform on-site surveys at least once every five years unless a need for the facility to be surveyed sooner is demonstrated. Due to lack of funding, this process has not performed regularly. As well, external quality control results are monitored on an on-going basis.

- **What are the implications of not being accredited?**

  If a facility is not accredited, it must not perform diagnostic procedures for clinical purposes.

- **Is there a centralized laboratory for cervical smears?**

  There is no centralization of services for cytology. Although this matter has been discussed by various committees over the past several years, there has not been general consensus that centralization of services is the way to go for Manitoba. However, the idea of a central registry has received much more support and discussion continues on this point.

- **If not, where are cervical smears sent?/ # of laboratories?**

  Currently, eight (8) hospital and six (6) private laboratories perform cytology procedures.

- **How is quality control ensured on an on-going basis?**

  In 1988 a comprehensive review was done of all cervico-vaginal gynaecological laboratories in Manitoba. The resulting report and recommendations were forwarded to the College of Physicians and Surgeons, and Manitoba Health. Subsequently, the College wrote to the Medical Directors of the Laboratories asking whether or not they were in compliance with the recommendations.

  Along with the report, a request was made to Manitoba Health that funding be provided for a comprehensive laboratory accreditation program. Such monies were recently granted. In March 1995, a Cytology Working Group was established. This committee was charged by the College to review and reorganize quality assurance programs for cytology laboratories in Manitoba. To date, they have had three meetings.

- **Additional information:**

  A Provincial Laboratory Committee has been struck by the Manitoba Government to review diagnostic laboratory services in Manitoba. A draft report should be available by January 16, 1995 and circulated amongst affected health care agencies shortly thereafter. It is not known at this time what impact there will be on the activities of MANQAP.

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ONTARIO

■ Who licenses laboratories in Ontario?

The operation of medical laboratories in Ontario is governed by the Laboratory and Specimen Collection Centre Licensing Act (LSCCLA) and its Regulations. This legislation authorizes the Ministry of Health to license and inspect laboratories, in addition to making participation in proficiency testing mandatory. Licenses are renewed annually.

Mandatory proficiency testing is carried out by the Ontario Medical Association's Laboratory Proficiency Testing Program (LPTP) on behalf of the Ministry of Health.

The Laboratory Licensing and Inspection Service (LLIS) administers the LSCCLA. Through the licensing and inspection process, LLIS ensures that medical laboratories and specimen collection centres operate within acceptable standards and that the availability of laboratory services reflects community needs.

■ Who accredits laboratories in Ontario?

Hospital facilities may be accredited by the Canadian Council for Health Services Accreditation (CCHSA). Private laboratory facilities are not accredited. However, the LLIS inspects all laboratories every 18 months.

■ What is the process by which labs are assessed for licensure?

- LLIS utilizes a check list in its inspection process.
- LPTP has a pro forma for the on-site consultation process.
- All laboratories are encouraged to follow practice guidelines issued by the Quality Assurance Committee of the Canadian Society of Cytology.
- The LPTP Cytology Committee has also prepared a guideline.

■ What are the implications of not being accredited?

When hospitals are accredited for the Canadian Council for Health Services Accreditation (CCHSA) service, laboratory function within the facility is assessed. The assessment is mainly within the context of the ability of the laboratory to function within the health care teams of the hospital. The specific areas of the laboratory and the way in which they do their work are not accredited.. The closest thing to an accreditation process in Ontario is the combined function of the LLIS (though inspection) and LPTP (through performance review and consultation process).

- **Is there a centralized laboratory for cervical smears?**

  There is no centralized laboratory for cervical smears in Ontario.

- **If not, where are cervical smears sent? # of laboratories?**

  At the present time there are a total of 109 laboratories in Ontario that are licensed to process cervical-vaginal cytology specimens. This includes 70 hospital and 39 private laboratories.

- **How do you ensure quality control on an on-going basis?**

  Routine inspections are conducted on a regular basis as time and resources permit. Those facilities in which serious problems are identified, either through the inspection process or via the proficiency testing route, are inspected more frequently. Once the problems are resolved, the facility will revert to a routine inspection schedule.

  The LPTP Cytology Committee has conducted an annual cervico-vaginal proficiency testing survey for seventeen years.

  LPTP's emphasis is on education rather than disciplinary actions. LPTP has a consultation service available to those laboratories identified as experiencing difficulties on LPTP surveys. A consultation team visits the laboratory and the resulting report includes recommendations for improvement.

- **Additional Information:**

  To facilitate good quality practice, LPTP Cytology Committee recommends that any laboratory which offers cytology services (other than simply a referral service to another laboratory) should:

  1. prepare all material on-site;

  2. screen all material at the same site at which it is prepared;

  3. arrange for the review and sign-out of material by the qualified laboratory physician at the same site; and,

  4. store report file copies and slides at the same site.

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QUÉBEC

- **Who licenses laboratories in Québec?**

  At this time, there is no private cytology laboratory in Quebec; all are located within public hospital facilities.

- **Who accredits laboratories in Québec?**

  There is no formal mechanism for accreditation.

- **Is there a centralized laboratory for cervical smears?**

  Cytology services are not centralized. Certain services handle a heavy volume of analyses and operate as referral centres for smaller labs.

- **How do you ensure quality control on an on-going basis?**

  "Quality control" is done according to the traditional mechanisms for assessment of medical acts, responsibility for which is assigned by law to the CMDP of the hospital.

- **Additional Information:**

  The recently constituted provincial advisory committee intends to undertake an examination of the delivery of cervical cancer screening activities within the province. It is possible that this operation may lead to a reconfiguration of our services with a view to an integrated and systematic program, as is already the case for breast cancer screening.

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NEW BRUNSWICK

- **Who licenses laboratories in New Brunswick?**

  The Minister of Health and Community Services, through the Hospital Act, gives hospitals the authority to operate and deliver services.

  A provincial Master Plan of Hospital Services prescribes those services which will be provided by the nine (9) Hospital Corporations in New Brunswick.

  There are no private hospitals or private laboratories in New Brunswick.

- **Who accredits laboratories in New Brunswick?**

  New Brunswick hospitals are accredited by the Canadian Council on Health Services Accreditation (CCHSA). As well, there are New Brunswick Standards on Laboratory Services Delivery.

- **What is the process by which labs are assessed for licensure?**

  Gynaecology cytology services are under the direction of the Laboratory Directors of the Regional Hospital Corporations. All directors are pathologists. All gynaecology cytology screening procedures are performed by certified and registered cytotechnologists.

- **How often is accreditation reviewed?**

  Hospitals are generally accredited every two to three years.

- **Is there a centralized laboratory for cervical smears?**

  A centralized laboratory for screening cervical smears does not exist in New Brunswick. Rather, the service is regionalized.

- **If not, where are cervical smears sent? # of laboratories?**

  Gynaecology cytology laboratory services in New Brunswick are currently provided by eight (8) out of nine regional hospitals.

- **How do you ensure quality control on an on-going basis?**

New Brunswick does not have an established external proficiency testing program in cytology. However, each cytology laboratory adheres to established practices of the experts. Most laboratories participate in an external proficiency or check sample program offered by the College of American Pathologist and/or the American Society of Clinical Pathologists. In addition each laboratory has a well established internal quality assurance program which includes:

a. Ten to twenty percent of all negative cervical smears are re-screened by a pathologist or senior technologist.

b. All abnormal smears are rechecked by a senior cyto-technologist and reported by a pathologist.

c. There is on-going correlation of tissue biopsies and cervical smears.

d. Previous cases are reviewed when indicated ie. if some level of atypia is noted.

e. The Cytology requisition/report form is standardized across the province. This does not ensure however, that professional comments are standardized. Pathologists and cytotechnologists are addressing this issue.

f. Maximum and minimum levels for the number of slides screened are reviewed as part of the performance evaluation of cytotechnologists.

g. Cytology rounds are held on a regular basis.

h. The regional laboratory directors meet regularly with members of Hospital services, Department of Health and Community Services, with Quality Assurance as an agenda item.

Further, quality assurance measures include membership in the following organizations: International Society of Cytology (which requires revalidation of members); Canadian Society of Cytology; Canadian Society of Laboratory Technologists (which offers several continuing education courses in cytology); Canadian Association of Pathologists; and College of American Pathologists.

- **Additional Information:**

  Laboratories are becoming computerized which will eventually enhance quality assurance activities.

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NOVA SCOTIA

The responses include activities and conditions at the Victoria General Hospital (VGH). The VG Hospital processes 43% of all Pap smears annually in Nova Scotia.

- **Who licenses laboratories in Nova Scotia?**

  Laboratories in Nova Scotia are not licensed.

- **Who accredits laboratories in Nova Scotia?**

  The Canadian Council on Health Services Accreditation (CCHSA) accredits laboratories in Nova Scotia.

  All laboratories processing cervical smears in Nova Scotia are hospital-based and therefore fall under hospital accreditation standards. There are no private laboratories in Nova Scotia.

  The CCHSA accreditation process will change nationally with the addition of a Quality Improvement component not currently included.

  The Victoria General Hospital (VGH) is moving to prepare itself for CAP (College of American Pathologists) accreditation in addition to CCHSA in the next two years.

- **What is the process by which labs are assessed for licensure?**

  - CCHSA — Standards of Care
  - Commission on Laboratory Accreditation (College of American Pathologists) — Inspection Checklist for Anatomic Pathology and Cytology
  - Nova Scotia Gynaecological Cancer Screening Programme Quality Assurance Guidelines and Activities

  The VGH laboratory is assessed through the above three means. The VGH also has its own Accreditation Standards for Laboratory Services. These standards are not used outside this institution for assessment.

- **How often is accreditation reviewed?**

  Accreditation is reviewed every three years at the Victoria General Hospital (VGH). In the interim the VGH requires each service to do 'self and peer accreditation with reports'.

- **Is there a centralized laboratory for cervical smears?**

  There is no centralization of services for cytology.

- **If not, where are cervical smears sent? # of laboratories?**

  Cytology is performed in nine (9) hospital-based laboratories in the province, all of which are participants of the Nova Scotia Gynaecological Cancer Screening Programme (NSGCSP).

- **How do you ensure quality control on an on-going basis?**

  All laboratories in Nova Scotia belong to the basic CAP Program; the Cytology component is optional for laboratories and is now used in four of the nine laboratories practicing gynaecological cytology. Each of the nine laboratories have an onsite pathologist responsible for quality control. This responsibility is vested in the pathologist by the institution and the hospital and its Board of Directors are ultimately responsible for quality control in their institution. The Nova Scotia Department of Health employs a Lab Consultant who performs regular visits to each institution. Laboratories participate in:

  - Canadian Society of Cytology Guidelines for Quality Assurance Programs
  - NSGCSP Quality Assurance Guidelines for Gynaecological Cytology
  - Provincial Quality Assurance Activities of the NSGCSP

  The Victoria General Hospital's external quality control processes include CAP Quality Assurance Activities and participation in the LPTP (Laboratory Proficiency Testing Program) Activities.

- **Additional Information:**

  The Nova Scotia Gynaecological Cancer Screening Programme (NSGCSP) is mandated, by the provincial Department of Health, to "ensure that a uniform standard of screening is provided to all women throughout Nova Scotia." Participation in the NSGCSP includes the following:

  1. Forwarding of demographic and clinical information on all Pap smears performed in Nova Scotia to the Central Cytology Registry. The Registry has captured this information since 1978. Laboratories forward data to the Registry on hard copy or electronically.

  2. Development of and cooperation with Provincial Quality Assurance Activities of the NSGCSP and adherence to NSGCSP Quality Assurance Guidelines for Gynaecological Cytology (based on the Canadian Society of Cytology Guidelines for Quality Assurance Programs in Cytopathology, February 18, 1989).

3. Participation in regular laboratory site review.

4. Representation on subcommittees and workgroups of the NSGCSP.

Accreditation of laboratories processing cervical smears is part of hospital accreditation and not the domain of the NSGCSP.

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PRINCE EDWARD ISLAND

- **Who licenses laboratories in Prince Edward Island?**

  Laboratories are not licensed within the province of Prince Edward Island. All laboratories exist within established hospitals and no private laboratories exist. Because Prince Edward Island does not have any private laboratories, it does not have a provincial licensing mechanism in place.

- **Who accredits laboratories in Prince Edward Island?**

  The only accreditation process that occurs in laboratories is through the Canadian Council on Health Services Accreditation (CCHSA).

- **How often is accreditation reviewed?**

  Accreditation occurs every two to three years, as a part of the general hospital accreditation process (CCHSA).

- **Is there a centralized laboratory for cervical smears?**

  All cytology is provided by the main laboratory, situated at the Queen Elizabeth Hospital in Charlottetown.

  The six smaller hospitals in the province have limited capacity and handle only those tests that require emergency laboratory response.

  The Prince County Hospital in Summerside is the only other facility that has a pathologist on site.

- **How do you ensure quality control on an on-going basis?**

  As a part of the general hospital accreditation process (CCHSA) which occurs every two or three years, the laboratory services are evaluated but this is not a detailed examination. The Queen Elizabeth Hospital laboratory uses the "Proficiency Program" offered by the U.S. College of American Pathologists (CAP) to evaluate their performance on specific tests but they are under no legal imperative to do so.

  The Queen Elizabeth Hospital laboratory offers in-province quality assurance services to the smaller facilities.

- **Additional Information:**

  CAP offers an intensive accreditation specifically for laboratories, and the Queen Elizabeth Hospital is considering subscribing to this service.

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NEWFOUNDLAND and LABRADOR

- **Who licenses laboratories in Newfoundland?**

  Laboratories are not licensed within the province of Newfoundland and Labrador. All laboratories exist within established hospitals and no private laboratories exist.

- **Who accredits laboratories in Newfoundland?**

  Laboratories are operated through the provincial hospitals and are accredited within the hospital by the Canadian Council on Health Services Accreditation (CCHSA). There are currently no private laboratories in Newfoundland and Labrador.

- **Is there a centralized laboratory for cervical smears?**

  There is no centralized laboratory for cervical smears. However, the Provincial Cytology Laboratory operated by the General Hospital in St. John's is the major laboratory for referrals, and it performs 60% of the total provincial workload for cervical smears.

- **If not, where are cervical smears sent? # of laboratories?**

  Exclusive of the Provincial Cytology Laboratory, there are six other hospital laboratories performing cervical smears. They receive the majority of the workload in their geographic area. The balance, plus the remainder of the province, forwards their cervical smears to the Provincial Cytology Laboratory.

- **How do you ensure quality control on an on-going basis?**

  Each laboratory has a quality control program. Generally this includes:

  1. Review of all abnormal results by cyto supervisor or pathologist.

  2. Approximately 10% of all normal results as reported by the cyto are reviewed similar to above.

  3. The majority of Cytology Laboratories participate in external proficiency testing programs offered by the College of American Pathologists or similar.

- **Additional information:**

  Currently there are no private laboratories within the province of Newfoundland and Labrador. Private diagnostic laboratories are governed by the Department of Health Act Regulation which prohibits the operation of such laboratories without the prior written consent of the Minister of Health.

Discussions are underway to centralize cytology services to the Provincial Cytology Laboratory. A copy of a study which is currently being implemented is available.

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Appendix B
Selected Commentary From the Working Group Sessions

Many important comments and observations were made in the working group sessions of the Workshop. Upon analysis of the comments we were pleased to see that there was a consistency of content from across the country. We felt that the quality and consistency of the comments was such that it is important that we share them with the public as they raise some interesting and pertinent issues. The organization of the comments varies with the question that is being answered. Where is was appropriate to condense comments, it has be done. As these were recorded by the notetakers during the working-group sessions themselves, the text is quite informal and remains non-attributed.

Appendix B1
Facilitators and barriers to implementation of comprehensive cervical screening programs

BRITISH COLUMBIA/ALBERTA

FACILITATORS

Champion: Need a champion/leader to push the issue forward. Could we use the word "advocacy"?

Women: Need a broad-based push by women for the program to be implemented.

Information Systems: Alberta is moving toward a centralized information system, though not specifically in relation to cervical cancer. So speak in terms of a centralized integrated information system.

BARRIERS

The 1989 Workshop Report is too long. If it is not read in its entirety then you might think it simply advocates testing every three years.

Lack Of Clear Goals/Standards: Women and physicians do not know how often the test should be done.

Data: Lack of data on levels of cervical cancer belies the seriousness of the problem in the public perception. Professionals do not believe in the need for more programs. Questionable accuracy of data on incidence rates.

Priorities: Cervical cancer is not an issue because it is not perceived to be on the public agenda. There is a relatively low health burden in comparison to other cancers — cervical cancer is the eleventh most common cancer in women. Provincial health officials do not read the documents because the documents are not deemed important. Public pressure is needed.

Lack of Consistency/Quality: Anxiety associated with the waiting involved in the screening program, anxiety over abnormalities or false positives appear.

Cost: Might be a potential savings -but many things could be improved with a better-managed health care system. Repeated tests could flood the system economically. What about the impact of the cancer on peoples' lives? Not going to win the argument for a comprehensive program using the numbe[illegible]me.

SASKATCHEWAN/ NORTHWEST TERRITORIES.

FACILITATORS

The 1976 Walton Report.

BARRIERS

Lack of Standards and Quality Assurance: Both Saskatchewan and NWT delegates felt that what is not emphasized is that 2/3 inappropriate sampling is due to physicians taking inappropriate samples.

Inadequate testing: Women who are poor and live in inner city or rural areas have a lower incidence of screening than other women. Physicians cannot be counted on to reach poorer women.

Public Advocacy: A major impediment is that there is no grass roots movement. There is no strong pressure for change and there is a lack of focus, unlike the case with breast cancer.

Cost

MANITOBA/ONTARIO

FACILITATORS

A somewhat coordinated care and treatment system for cancer exists in both provinces. Manitoba has the political and professional impetus, but lacks a mechanism to ensure implementation. Ontario has professional commitment with the tentative support of government.

BARRIERS

Lack of Prioritization: Competing demands on time and resources, at all levels. No clear allocation of responsibility. Low priority is an impediment. When you look only at the number of deaths from this disease vs other cancers, the dollars are put toward the higher mortality cancers. But we're dealing with something you can **prevent**.

Stakeholders: Too many stakeholders. Difficult to manage. Perhaps the stakeholders should be invited in at different stages of the program's development.

National Standards: We need to set standards and goals that everyone agrees to.

QUEBEC/NEW BRUNSWICK/PRINCE EDWARD ISLAND

FACILITATORS

Quality Accreditation: No variations in quality in PEI because there is only one lab. Accreditation by the American Pathologist Association (APA) — no accreditation available in Canada as of yet. In New Brunswick, labs are committed to quality, follow the American guidelines, and are accredited by the APA; most labs are located in hospitals In general, the group agreed that professionals' commitment to quality, and provincial accreditation programs would create the impetus.

BARRIERS

Absence of accreditation in Canada

Government imposition

Money for computers and software

Absence of financial incentives for recruitment, such as for finding positives and targeting populations at risk: The group agreed there is nothing in the system that would make family physicians want to perform a pap smear. The view held among family physicians that they have the right to select their patients; high-risk and needy patients add an extra burden Screening should be included in general exams.

NOVA SCOTIA/ NEWFOUNDLAND

FACILITATORS

1) **Leadership**: Provinces with a champion.

2) **Opportunity**: Nova Scotia was provided with an opportunity and grabbed it.

3) **Partnerships**: Provincial and territorial working groups could be convinced to provide leadership as well. Newfoundland depended on an informal, spontaneous and ad hoc process.

BARRIERS

Cost of analysis: Nova Scotia is faced with an economic hurdle. There is a need money to analyze information.

Lack of standards: Having no standards and no one to implement standards are also impediments. Variations with clinicians is a problem. But the **role of a program is to facilitate process.** A peer review should suggest how to change rather than punish. Clinics do colposcopy voluntarily and have helped to develop programs. Can't expect them to be aware of all developments.

Appendix B2
What is the evidence needed to convince policy makers and funders of the need for a comprehensive program?

Public Pressure

Governments have got to be persuaded that the voting public (e.g., the community) wants a comprehensive cervical cancer screening program by:

- Public requests, letters to Minister
- Professional groups can represent the public and make the case to government i.e., the establishment can drive the community.

Those who want a comprehensive screening program must create the public demand. Furthermore, it is optically important for women's groups to work alongside medical groups. In Australia a coalition between groups like gynaecologists, pathologists, public health workers, physicians & women's organizations. created a dynamic force. "They couldn't dismiss us".

This might be accomplished by :

- publicizing the fact that certain populations are at risk — older women, immigrant women, native women.
- this might be framed as a **gender** issue. However, it must be noted that women at high risk for cervical cancer often have other pressing priorities.

Cost

Even though there is a lot of evidence favouring a comprehensive program, especially in British Columbia , other provinces are not stimulated to act. Something else is needed. A convincing case may rest on the way the issues are presented, and not just with basic economics. Better information on cost benefits would give weight to the argument. Furthermore, why are we assuming that a comprehensive screening program would cost more than at present?

There must be ready responses to the following types of questions:

- Can we prove cost-effectiveness and long-term savings if treated early ?
- Can we demonstrate that existing programs are not cost-effective and that the numbers of unnecessary colposcopies could be reduced by 60% with registries, good policies and good programs ?
- What does it cost to treat women with cervical cancer?

- How many women per/yr. are diagnosed with abnormalities that require follow-up and invasive cervical cancer, how many are dying, and what is the cost of their treatment ?
- How can we reallocate funds to reach the high-risk, hard-to-reach ?

Quality Assurance

- Are we providing the right service and can it be done better ? "I'm not sure why anyone wants to do test inappropriately; it seems like there's misinformation in the system".
- Is it worth to do it better ? Getting people to look at the practices so that unnecessary procedures aren't performed.

Other

- Can we reduce mortality?
- Are these activities consistent with health care reform ?

Appendix C

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